**Law Office of Michelle Peretz PLLC**

CONFIDENTIAL

# ESTATE PLANNING & LONG-TERM CARE PLANNING QUESTIONNAIRE

This questionnaire is designed to help us gather the information necessary to properly plan to protect your assets (or the assets of a family member or friend), assess possible estate tax exposure (Federal and NYS) and evaluate resources available should there be a need for Long-Term Care. Whether you are a new or an established client, we have found this questionnaire extremely helpful and we ask your indulgence in completing it fully. Those questions that do not apply to you, your family, or your financial situation may simply be marked "**N/A**". Please feel free to attach additional pages where space is insufficient, or to provide other information you feel is relevant.

---

DATE: _____

## SECTION 1. NAME AND CONTACT INFORMATION

Person Completing Form: _____
(first) (middle) (last)

Home Address: _____

_____

Relationship to Client: _____

Client's Full Name: _____
(first) (middle) (last)

Spouse's Full Name: _____
(first) (middle) (last)

Home Address: _____

_____

| | **Client** | **Spouse** |
|---|---|---|
| Telephone Numbers: | _____ (home) | _____ (home) |
| | _____ (cell) | _____ (cell) |
| Date of Birth: | _____ | _____ |
| Former/Maiden Names: | _____ | _____ |
| US Citizen?: | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Social Security Number: | _____ | _____ |

Military Service: _____ _____

Date of Death: _____ _____

## SECTION 2. MARITAL INFORMATION

**A.** Date of Marriage: _____

**B.** Place of Marriage: _____
(city) (state or province) (country)

**C. Client's Former Spouses:**

**1.**

| | | | | | |
|---|---|---|---|---|---|
| Name of Former Spouse: | | Date of Marriage (MM/DD/YYYY) | | County/State of Marriage | |
| Type of Termination: (Death / Divorce) | | Date of Termination (MM/DD/YYYY) | | **If deceased, provide copy of death certificate and skip to next section.** | |
| Divorced (continue) | MUST PROVIDE JUDGMENT OF DIVORCE, SETTLEMENT AGREEMENT AND ANY SUBSEQUENT AMENDMENTS | | | | |
| Former Spouse still living? (Y/N) | | If YES, describe relationship | | | |

**2.**

| | | | | | |
|---|---|---|---|---|---|
| Name of Former Spouse: | | Date of Marriage (MM/DD/YYYY) | | County/State of Marriage | |
| Type of Termination: (Death / Divorce) | | Date of Termination (MM/DD/YYYY) | | **If deceased, provide copy of death certificate and skip to next section.** | |
| Divorced (continue) | MUST PROVIDE JUDGMENT OF DIVORCE, SETTLEMENT AGREEMENT AND ANY SUBSEQUENT AMENDMENTS | | | | |
| Former Spouse still living? (Y/N) | | If YES, describe relationship | | | |

**3.**

| | | | | | |
|---|---|---|---|---|---|
| Name of Former Spouse: | | Date of Marriage (MM/DD/YYYY) | | County/State of Marriage | |
| Type of Termination: (Death / Divorce) | | Date of Termination (MM/DD/YYYY) | | **If deceased, provide copy of death certificate and skip to next section.** | |
| Divorced (continue) | MUST PROVIDE JUDGMENT OF DIVORCE, SETTLEMENT AGREEMENT AND ANY SUBSEQUENT AMENDMENTS | | | | |
| Former Spouse still living? (Y/N) | | If YES, describe relationship | | | |

**D. Spouse's Former Spouses:**

**1.**

| | | | | | |
|---|---|---|---|---|---|
| Name of Former Spouse: | | Date of Marriage (MM/DD/YYYY) | | County/State of Marriage | |
| Type of Termination: (Death / Divorce) | | Date of Termination (MM/DD/YYYY) | | **If deceased, provide copy of death certificate and skip to next section.** | |
| Divorced (continue) | MUST PROVIDE JUDGMENT OF DIVORCE, SETTLEMENT AGREEMENT AND ANY SUBSEQUENT AMENDMENTS | | | | |
| Former Spouse still living? (Y/N) | | If YES, describe relationship | | | |

**2.**

| | | | | | |
|---|---|---|---|---|---|
| Name of Former Spouse: | | Date of Marriage (MM/DD/YYYY) | | County/State of Marriage | |
| Type of Termination: (Death / Divorce) | | Date of Termination (MM/DD/YYYY) | | **If deceased, provide copy of death certificate and skip to next section.** | |
| Divorced (continue) | MUST PROVIDE JUDGMENT OF DIVORCE, SETTLEMENT AGREEMENT AND ANY SUBSEQUENT AMENDMENTS | | | | |
| Former Spouse still living? (Y/N) | | If YES, describe relationship | | | |

**3.**

| | | | | | |
|---|---|---|---|---|---|
| Name of Former Spouse: | | Date of Marriage (MM/DD/YYYY) | | County/State of Marriage | |
| Type of Termination: (Death / Divorce) | | Date of Termination (MM/DD/YYYY) | | **If deceased, provide copy of death certificate and skip to next section.** | |
| Divorced (continue) | MUST PROVIDE JUDGMENT OF DIVORCE, SETTLEMENT AGREEMENT AND ANY SUBSEQUENT AMENDMENTS | | | | |
| Former Spouse still living? (Y/N) | | If YES, describe relationship | | | |

## SECTION 3. CHILDREN

List all children. Copy and attach additional pages, if needed. Total number of children: _____

**1.**

| | | | | | |
|---|---|---|---|---|---|
| Full Name of CHILD: | | | Date of Birth: (MM/DD/YYYY) | | Parents: Client [ ]<br>Spouse [ ]<br>Both [ ] |
| Street Address<br>City, State, Zip: | | | | | Social Security Number<br>_____ - ___ - _____ |
| Cellphone: | | | Email: | | |
| Adopted: [ ]<br>Deceased: [ ] | Date of Adoption:<br>_____ | Date of Death:<br>_____ | Does this child have living children? (Y/N)<br>_____ | Please identify if this CHILD or any of their children has a disability:<br>_____<br>_____ | |

**2.**

| | | | | | |
|---|---|---|---|---|---|
| Full Name of CHILD: | | | Date of Birth: (MM/DD/YYYY) | | Parents: Client [ ]<br>Spouse [ ]<br>Both [ ] |
| Street Address<br>City, State, Zip: | | | | | Social Security Number<br>_____ - ___ - _____ |
| Cellphone: | | | Email: | | |
| Adopted: [ ]<br>Deceased: [ ] | Date of Adoption:<br>_____ | Date of Death:<br>_____ | Does this child have living children? (Y/N)<br>_____ | Please identify if this CHILD or any of their children has a disability:<br>_____<br>_____ | |

**3.**

| | | | | | |
|---|---|---|---|---|---|
| Full Name of CHILD: | | | Date of Birth: (MM/DD/YYYY) | | Parents: Client [ ]<br>Spouse [ ]<br>Both [ ] |
| Street Address<br>City, State, Zip: | | | | | Social Security Number<br>_____ - ___ - _____ |
| Cellphone: | | | Email: | | |
| Adopted: [ ]<br>Deceased: [ ] | Date of Adoption:<br>_____ | Date of Death:<br>_____ | Does this child have living children? (Y/N)<br>_____ | Please identify if this CHILD or any of their children has a disability:<br>_____<br>_____ | |

**4.**

| | | | | | |
|---|---|---|---|---|---|
| Full Name of CHILD: | | | Date of Birth: (MM/DD/YYYY) | | Parents: Client [ ]<br>Spouse [ ]<br>Both [ ] |
| Street Address<br>City, State, Zip: | | | | | Social Security Number<br>_____ - ___ - _____ |
| Cellphone: | | | Email: | | |
| Adopted: [ ]<br>Deceased: [ ] | Date of Adoption:<br>_____ | Date of Death:<br>_____ | Does this child have living children? (Y/N)<br>_____ | Please identify if this CHILD or any of their children has a disability:<br>_____<br>_____ | |

**5.**

| | | | | | |
|---|---|---|---|---|---|
| Full Name of CHILD: | | | Date of Birth: (MM/DD/YYYY) | | Parents: Client [ ]<br>Spouse [ ]<br>Both [ ] |
| Street Address<br>City, State, Zip: | | | | | Social Security Number<br>_____ - ___ - _____ |
| Cellphone: | | | Email: | | |
| Adopted: [ ]<br>Deceased: [ ] | Date of Adoption:<br>_____ | Date of Death:<br>_____ | Does this child have living children? (Y/N)<br>_____ | Please identify if this CHILD or any of their children has a disability:<br>_____<br>_____ | |

**6.**

| | | | | | |
|---|---|---|---|---|---|
| Full Name of CHILD: | | | Date of Birth: (MM/DD/YYYY) | | Parents: Client [ ]<br>Spouse [ ]<br>Both [ ] |
| Street Address<br>City, State, Zip: | | | | | Social Security Number<br>_____ - ___ - _____ |
| Cellphone: | | | Email: | | |
| Adopted: [ ]<br>Deceased: [ ] | Date of Adoption:<br>_____ | Date of Death:<br>_____ | Does this child have living children? (Y/N)<br>_____ | Please identify if this CHILD or any of their children has a disability:<br>_____<br>_____ | |

## SECTION 4. DISPOSITIVE PLANNING

In general, to whom and how do you want your property distributed upon your death? Think about your family members, friends, former benefactors, and charities, such as public benefit nonprofit organizations, educational or religious organizations. Typical examples are: SPOUSE, CHILDREN, SPOUSE AND CHILDREN, or provide names of other individuals and their relationship to you.

**A.** First-choice beneficiaries: _____

_____

Consider to whom your property should go if your first-choice beneficiaries do not survive you, or - if your property is left in Trust - if they do not survive until complete distribution is made (i.e., charities, other siblings, spouse of child, etc.).

**B.** Second-choice beneficiaries: _____

_____

**C.** Third-choice beneficiaries: _____

_____

**D.** Any specific disposition of your residence? _____

_____

**E.** Any specific gifts of special articles, such as art or jewelry? _____

_____

**F.** Any specific disposition of household and personal effects? _____

_____

**G.** Other information you think is important to your estate planning: _____

_____

_____

_____

_____

_____

_____

_____

## SECTION 5. FIDUCIARIES

Please consider who you want to put in charge of carrying out your instructions. In a Last Will and Testament, this person is called the Executor. In a Trust, this person is called a Trustee. You may name more than one Fiduciary in a position. An odd number of Fiduciaries is always preferable to avoid deadlock decisions. If you select more than one Fiduciary, you must state whether they can each act separately, or if they MUST act jointly (together).

### A. EXECUTORS:

**Primary Executor(s):** **ONE [ ]** **If Multiple: ACT SEPARATE [ ]**

**MULTIPLE [ ]** **MUST ACT JOINTLY [ ]**

_____ _____
(name) (relationship)

_____ _____
(name) (relationship)

_____ _____
(name) (relationship)

Additional notes: _____

**Successor Executor(s):** **ONE [ ]** **If Multiple: ACT SEPARATE [ ]**

**MULTIPLE [ ]** **MUST ACT JOINTLY [ ]**

_____ _____
(name) (relationship)

_____ _____
(name) (relationship)

_____ _____
(name) (relationship)

Additional notes: _____

**Please note if any of these people named as Primary or Successor Executor have been incarcerated, filed for bankruptcy or is an attorney?**

_____

_____

**B. TRUSTEES**

**Initial Trustee(s):** **ONE [ ]** **If Multiple: ACT SEPARATE [ ]**

**MULTIPLE [ ]** **MUST ACT JOINTLY [ ]**

_____ _____
(name) (relationship)

_____ _____
(name) (relationship)

_____ _____
(name) (relationship)

Additional notes: _____

**Successor Trustee(s):** **ONE [ ]** **If Multiple: ACT SEPARATE [ ]**

**MULTIPLE [ ]** **MUST ACT JOINTLY [ ]**

_____ _____
(name) (relationship)

_____ _____
(name) (relationship)

_____ _____
(name) (relationship)

Additional notes: _____

**C. GUARDIANS OF MINOR CHILDREN (Physical and Financial duties can be separate Guardians)**

**Primary Guardian(s):** **ONE [ ]** **If Multiple: ACT SEPARATE [ ]**

**MULTIPLE [ ]** **MUST ACT JOINTLY [ ]**

_____ _____ _____
(name) (relationship) (Physical / Financial / BOTH)

_____ _____ _____
(name) (relationship) (Physical / Financial / BOTH)

_____ _____ _____
(name) (relationship) (Physical / Financial / BOTH)

Additional notes: _____

**Successor Guardian(s):** **ONE [ ]** **If Multiple:** **ACT SEPARATE [ ]**

**MULTIPLE [ ]** **MUST ACT JOINTLY [ ]**

| (name) | (relationship) | (Physical / Financial / BOTH) |
|---|---|---|
| (name) | (relationship) | (Physical / Financial / BOTH) |
| (name) | (relationship) | (Physical / Financial / BOTH) |

Additional notes: _____

**D. AGENTS UNDER POWER OF ATTORNEY (FINANCIAL DECISIONS DURING LIFETIME ONLY)**

**1. Primary Agent(s):** **ONE [ ]** **If Multiple:** **ACT SEPARATE [ ]**

**MULTIPLE [ ]** **MUST ACT JOINTLY [ ]**

| (name) | (address) |
|---|---|
| (name) | (address) |
| (name) | (address) |

Additional notes: _____

**Successor Agent(s):** **ONE [ ]** **If Multiple:** **ACT SEPARATE [ ]**

**MULTIPLE [ ]** **MUST ACT JOINTLY [ ]**

| (name) | (address) |
|---|---|
| (name) | (address) |
| (name) | (address) |

Additional notes: _____
(name) (relationship)

**E. AGENTS UNDER HEALTH CARE POWER OF ATTORNEY (DURING LIFETIME ONLY)**

**LIST IN ORDER OF PRIORITY – ONLY ONE PERSON MAY SERVE AS AGENT AT A TIME**

**1.** _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

**2.** _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

**3.** _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

**4.** _____ _____
(name) (relationship)

_____ _____
(current address) (phone number)

## SECTION 6. HEALTH-RELATED PROBLEMS

Please describe any specific health-related problems.

**A. Client**

_____

_____

_____

**B. Spouse**

_____

_____

_____

## SECTION 7. CAPACITY

### A. MEMORY AND UNDERSTANDING

Are there any known problems with memory or understanding?

Client: [ ] Yes [ ] No

Spouse: [ ] Yes [ ] No

If yes, please explain:

_____

_____

_____

**B. OTHER ISSUES**

| | Client | Spouse |
|---|---|---|
| Able to sign name?: | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Able to speak?: | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Able to recognize friends and family?: | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Cognizant of property and possessions?: | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Able to leave current residence?: | [ ] Yes [ ] No | [ ] Yes [ ] No |

## SECTION 8. PHYSICIAN INFORMATION

Please list the name, specialty, address, and phone number of your primary physician.

| | Client | Spouse |
|---|---|---|
| Physician's Name: | _____ | _____ |
| Specialty: | _____ | _____ |
| Address: | _____ | _____ |
| | _____ | _____ |
| Business Phone: | _____ | _____ |

## SECTION 9. RESIDENCE -- OWNED

**A.** Owners: _____

**B.** How is title held? _____

**PLEASE PROVIDE A COPY OF THE DEED AND MOST RECENT TAX BILL**

**C.** Fair Market Value: $ _____

**D.** Mortgage Balance: $ _____

Is it a Reverse Annuity Mortgage (RAM)? [ ] Yes [ ] No

Basic Mortgage Terms: _____

**E.** Single Family Residence? [ ] Yes [ ] No

**F.** If the property is rental property, please provide the following:

1. Number of units: _____

2. Currently being rented? [ ] Yes [ ] No

3. Are tenants under lease? [ ] Yes [ ] No

**G.** If the property was purchased, please provide the following:

1. Date of Purchase: _____

2. Purchase Price: $ _____

**H.** If the property was inherited, please provide the following:

1. Month/Year Inherited: _____

2. Value when Inherited: $ _____

**I.** If improvements have been made to the property, please detail the value and nature of them:

_____

_____

_____

**J.** Have the owners used the capital gains tax exclusion? [ ] Yes [ ] No

**K.** If at least one occupant of the residence is a child of the individual in need of long-term care, has that child lived in the residence for at least 2 years? [ ] Yes [ ] No

**1.** If yes, has the child provided personal care to the parent that might have delayed the need for long-term care for the parent? [ ] Yes [ ] No

**2.** If so, please describe the nature and duration of the care provided:

_____

_____

_____

**L.** Does the person needing care have any living children who are disabled? [ ] Yes [ ] No

If yes, please describe the nature of the disability:

_____

_____

**M.** Does the owner have a sibling who has lived in the house for at least 1 year? [ ] Yes [ ] No

If yes, does the sibling still reside in the home? [ ] Yes [ ] No

## SECTION 10. RESIDENCE -- RENTED

**A.** Monthly Rent: $ _____

**B.** Type of Rental: [ ] Single Family [ ] Apartment [ ] Residential Care
[ ] Life Care [ ] Senior Housing

**C.** Rental/Lease Agreement? [ ] Yes [ ] No

**D.** Is Rent Subsidized? [ ] Yes [ ] No

If so, by whom and amount? _____

## SECTION 11. LONG-TERM CARE (LTC)

**A. Client**

Currently Receiving LTC? [ ] Yes [ ] No If YES, date started: _____

Name of Facility/Provider: _____

Address: _____

Business Phone: _____

Administrator or Contact: _____

**B. Spouse**

Currently Receiving LTC? [ ] Yes [ ] No If YES, date started: _____

Name of Facility/Provider: _____

Address: _____

Business Phone: _____

Administrator or Contact: _____

## SECTION 12. HOSPITAL

**A. Client**

Currently in Hospital?[ ] Yes [ ] No If YES, date admitted: _____

Name/location of hospital: _____

Description of medical issue:_____

Is LTC placement expected? [ ] Yes [ ] No If YES, likely to return home? [ ] Yes [ ] No

**B. Spouse**

Currently in Hospital?[ ] Yes [ ] No If YES, date admitted: _____

Name/location of hospital: _____

Description of medical issue:_____

Is LTC placement expected? [ ] Yes [ ] No If YES, likely to return home? [ ] Yes [ ] No

## SECTION 13 DEBT

Enter the outstanding balance of debt. For a married couple, be sure to include both spouses' debt. You may provide a copy of the most recent statement and additional pages if needed.

| Description/Type of Debt | Whose debt? | Creditor | Balance |
|---|---|---|---|
| Credit card (sample) | John and Jane's | US Bank | $ xx,xxx.xx |
| | | | $ |
| | | | $ |
| | | | $ |

## SECTION 14. INCOME

In completing the following section, use the "name on the check" rule; that is, the person whose name appears on the payment vehicle is the "owner" of the income.

### A. FIXED MONTHLY INCOME

| | | Client | Spouse | Joint |
|---|---|---|---|---|
| **1.** | Social Security: | $ | $ | $ |
| **2.** | R.R. Retirement: | $ | $ | $ |
| **3.** | Pension: | $ | $ | $ |
| **4.** | _____: | $ | $ | $ |
| **5.** | _____: | $ | $ | $ |

### B. NON-FIXED MONTHLY INCOME

| | | Client | Spouse | Joint |
|---|---|---|---|---|
| **1.** | Interest: | $ | $ | $ |
| **2.** | Dividends: | $ | $ | $ |
| **3.** | _____: | $ | $ | $ |
| **4.** | _____: | $ | $ | $ |
| **5.** | _____: | $ | $ | $ |
| **C.** | **TOTALS (A thru B):** | **$** | **$** | **$** |

## SECTION 15 ASSETS AND RESOURCES

**A. CASH AND BANK ACCOUNTS (CDs, Checking, Savings, etc.)**
**(Please provide copies of statements)**

| Name of Bank/Branch | Account No. | Type of Account | Balance/Value | How Title Held |
|---|---|---|---|---|
| Big Bank/Main St. (sample) | xxx-xxxx | Savings | $ xx,xxx.xx | Jointly w/ son |
| | | | $ | |
| | | | $ | |
| | | | $ | |
| | | | $ | |
| | | | $ | |

**B. SECURITIES (Bonds, Marketable Securities, etc. – Can provide Brokerage Statement)**
**(Please provide copies of statements)**

| Name of Company | Type of Sec. | # Shares/Face Val. | Cost | Current Val. | How Title Held |
|---|---|---|---|---|---|
| Acme Corp. (sample) | Common (or Preferred) | xx Shares | $ x,xxx.xx | $ x,xxx.xx | Sole owner |
| | | | $ | $ | |
| | | | $ | $ | |
| | | | $ | $ | |
| | | | $ | $ | |
| | | | $ | $ | |

**C. RETIREMENT ACCOUNTS (IRAs, Keoghs, etc.)**
**(Please provide copies of statements and beneficiary designations)**

| Name of Institution | Account No. | Owner | Beneficiary | Date Est. | Current Value |
|---|---|---|---|---|---|
| Big Broker (sample) | xxx-xxxx | Client | Spouse | Jan, 1970 | $ xx,xxx.xx |
| | | | | | $ |
| | | | | | $ |
| | | | | | $ |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | $ |
| | | | | | $ |

**D. REAL ESTATE**
**(Please provide copies of deeds and most recent tax bills)**

| Description (Location) | Cost (Basis) | Market Value | Mortgage Bal. | How Title Held |
|---|---|---|---|---|
| 123 Know Way (sample) | $ xxx,xxx.xx | $ xxx,xxx.xx | $ xx,xxx.xx | Joint tenant |
| | $ | $ | $ | |
| | $ | $ | $ | |
| | $ | $ | $ | |

**E. PERSONAL PROPERTY**

| | Market Value | How Title Held |
|---|---|---|
| Home Furnishings: | $ | |
| Cars, RVs, Boats, etc.: | $ | |
| Jewels, Furs, etc.: | $ | |
| : (other: collectibles, etc.) | $ | |
| : | $ | |
| : | $ | |

**F. BUSINESS INTERESTS**

If the person needing long-term care has any business interests, please provide a short description giving the name, location, percentage owned, names and relationship of co-owners, and the form of ownership (i.e., sole proprietorship, closely held corporation, partnership, etc.). Please bring a copy of any agreements, financial statements, etc.

### G. RIGHTS OR INTERESTS IN TRUSTS, ESTATES, OR PROSPECTIVE INHERITANCES

Briefly describe or give the name of the Trust in which the person needing long-term care has an interest, or the person who is the source of the inheritance. Please provide a copy of the instrument which creates the interest, if available. If not, please advise how we may obtain a copy.

### H. MISCELLANEOUS

If the person needing long-term care has any property interests not described above, please explain the nature of the interests and the estimated value of each (but not life insurance—see Section 20).

## SECTION 16. EXEMPT RESOURCES

Under the Medicaid rules, certain items are "exempt" from consideration as an available asset to pay for long-term care. Some of those items are listed below. Please indicate whether the person needing care has the listed items.

| | Client | Spouse |
|---|---|---|
| Burial plot: | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Irrevocable burial fund contract: | [ ] Yes [ ] No | [ ] Yes [ ] No |

## SECTION 17. PEOPLE PROVIDING ASSISTANCE

Who now has "assistance" responsibilities? That is, are any family members or other people providing custodial or other types of care to the person needing assistance? Please list name, phone number, and relationship to the person receiving the care.

**A. Responsible for Client:**

**1.** _____ _____ _____
(name of responsible person) (phone number) (relationship to person needing care)

**2.** _____ _____ _____
(name of responsible person) (phone number) (relationship to person needing care)

**B. Responsible for Spouse:**

**1.** _____ _____ _____
(name of responsible person) (phone number) (relationship to person needing care)

**2.** _____ _____ _____
(name of responsible person) (phone number) (relationship to person needing care)

## SECTION 18. UNAVAILABLE CHILDREN

If the person needing care has any children who are not to be relied upon to help with management or other needs of the parent, please list those children here and briefly explain why you believe they should not be relied upon.

_____

_____

## SECTION 19. MONTHLY COST OF LIVING

**A. HOUSING (ESTIMATED PER MONTH)**

| | Client | Spouse | Joint |
|---|---|---|---|
| **1.** If home is owned, total cost of mortgage, taxes, utilities, phone, etc.*: | $ | $ | $ |
| **2.** If home is rented, total rent, including maint. fees, if any: | $ | $ | $ |

* Is the senior citizen real property tax exemption being used? [ ] Yes [ ] No

Is the veterans real property tax exemption being used? [ ] Yes [ ] No

**B. INSURANCE PREMIUMS (PER MONTH)**

| | | Client | Spouse | Joint |
|---|---|---|---|---|
| **1.** | Health insurance: | $ | $ | $ |
| **2.** | Long-term care insurance: | $ | $ | $ |
| **3.** | _____ (specify): | $ | $ | $ |
| **4.** | _____ (specify): | $ | $ | $ |

**C. MEDICAL EXPENSES (ESTIMATED PER MONTH)**

| | | Client | Spouse | Joint |
|---|---|---|---|---|
| **1.** | Non-covered medications: | $ | $ | $ |
| **2.** | _____ (specify): | $ | $ | $ |
| **3.** | _____ (specify): | $ | $ | $ |

**D. BASIC LIVING EXPENSES (ESTIMATED PER MONTH)**

| | | Client | Spouse | Joint |
|---|---|---|---|---|
| **1.** | Food: | $ | $ | $ |
| **2.** | Entertainment and travel: | $ | $ | $ |
| **3.** | Support for children: | $ | $ | $ |
| **4.** | _____ (specify): | $ | $ | $ |
| **5.** | _____ (specify): | $ | $ | $ |

**E. TOTALS (A thru D): $ $ $**

## SECTION 20. HEALTH AND LTC INSURANCE

If the person needing care has Medicare Parts A, B, or D, private health or long-term care insurance, or is paying for a Medicare supplement policy, please provide the following information:

| Name of Insurer | Policy No. | Type of Policy | Monthly Prem. | If LTC, Daily Benefit |
|---|---|---|---|---|
| Acme Insurance | 123-45-6789 | Long-term care | $ 3,000 | $ 300.00 per day |
| (sample) | | | | |
| | | | $ | $ |
| | | | $ | $ |
| | | | $ | $ |

## SECTION 21. LIFE INSURANCE

If the person needing care has life insurance, please provide the following information:

| Name of Insurer | Policy No. | Type of Policy | Monthly Prem. | Cash Surrender Value |
|---|---|---|---|---|
| Acme Insurance | 123-45-6789 | Whole Life | $ 1,000 | $ 10,000 |
| (sample) | | | | |
| | | | $ | $ |
| | | | $ | $ |
| | | | $ | $ |

## SECTION 22. PLANNING AND OTHER DOCUMENTS

Do you have the following documents currently in place? Please provide a copy of each document.

| | **Client** | **Spouse** |
|---|---|---|
| Will: | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Revocable Living Trust: | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Pour-Over Will: | [ ] Yes [ ] No | [ ] Yes [ ] No |
| General Durable Power of Attorney: | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Health Care Power of Attorney (or Proxy): | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Living Will: | [ ] Yes [ ] No | [ ] Yes [ ] No |
| _____: | [ ] Yes [ ] No | [ ] Yes [ ] No |
| _____: | [ ] Yes [ ] No | [ ] Yes [ ] No |
| _____: | [ ] Yes [ ] No | [ ] Yes [ ] No |

(specify)

## SECTION 23. TRANSFERS WITHIN 60 MONTHS

Has the person needing care (or his or her spouse) gratuitously transferred property to someone other than transferor's spouse within the past 60 months? If so, please provide the following information and **copies of gift tax returns, if available**: Please include transfers for financial assistance to anyone, other than in exchange for work.

**A. Client**

| | Recipient | Amount/Value of Gift | Date of Gift |
|---|---|---|---|
| **1.** | _____ | $ _____ | _____ |
| **2.** | _____ | $ _____ | _____ |
| **3.** | _____ | $ _____ | _____ |
| **4.** | _____ | $ _____ | _____ |

**B. Spouse**

| | Recipient | Amount/Value of Gift | Date of Gift |
|---|---|---|---|
| **1.** | _____ | $ _____ | _____ |
| **2.** | _____ | $ _____ | _____ |
| **3.** | _____ | $ _____ | _____ |
| **4.** | _____ | $ _____ | _____ |

## SECTION 24. TRANSFERS TO OR FROM TRUSTS

Has the person needing care (or his or her spouse) transferred property into a Trust—like an Irrevocable Life Insurance Trust (ILIT)—or directed that property be transferred from a Trust (usually a Revocable Trust) within the past 60 months? If so, please provide the following information:

**A. Client**

| | Name of Trust | Amount/Value of Transfer | Date of Transfer |
|---|---|---|---|
| **1.** | _____ | $ _____ | _____ |
| **2.** | _____ | $ _____ | _____ |
| **3.** | _____ | $ _____ | _____ |

**B. Spouse**

| Name of Trust | Amount/Value of Transfer | Date of Transfer |
|---|---|---|
| **1.** _____ | $ _____ | _____ |
| **2.** _____ | $ _____ | _____ |
| **3.** _____ | $ _____ | _____ |

## SECTION 25. CLIENT'S GOALS

What are your goals?

_____

_____

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